		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021238

Facility Name: P A Peterson Home F/T Aged

Address: 1311 Parkview Ave. (Number) Rockford (City) 61107 (Zip Code)

County: Winnebago

Telephone Number: (815) 399-8832 **Fax #** (815) 399-8342

IDPA ID Number: 36-2584799-004

Date of Initial License for Current Owners: 1941

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501(C) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Dorkas Cruz **Telephone Number:** (847) 635-4633

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/01/99 to 6/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Frederick Aigner
(Title) President

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	112	Skilled (SNF)	112	40,992	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	56	Sheltered Care (SC)	56	20,496	5
6		ICF/DD 16 or Less			6
7	168	TOTALS	168	61,488	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			7,969	7,969	8
9	SNF/PED					9
10	ICF	5,262	22,099		27,361	10
11	ICF/DD					11
12	SC		7,813		7,813	12
13	DD 16 OR LESS					13
14	TOTALS	5,262	29,912	7,969	43,143	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 70.16%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [N/A]

I. On what date did you start providing long term care at this location?
Date started 1941

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 7,969

Medicare Intermediary Adminastar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/00 Fiscal Year: 6/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	290,627	23,477	21,686	335,790		335,790		335,790			1
2	Food Purchase		255,625		255,625		255,625	(8,073)	247,552			2
3	Housekeeping	119,879	33,900	3,235	157,014		157,014		157,014			3
4	Laundry	14,321	3,584	121,445	139,350		139,350		139,350			4
5	Heat and Other Utilities			155,290	155,290	3,244	158,534	(11,874)	146,660			5
6	Maintenance	115,318	41,332	117,030	273,680	4,464	278,144	(3,015)	275,129			6
7	Other (specify):* Rubbish Removal			13,055	13,055	1,683	14,738		14,738			7
8	**TOTAL General Services**	540,145	357,918	431,741	1,329,804	9,391	1,339,195	(22,962)	1,316,233			8
	B. Health Care and Programs											
9	Medical Director			34,071	34,071		34,071		34,071			9
10	Nursing and Medical Records	2,187,707	380,648	445,771	3,014,126		3,014,126		3,014,126			10
10a	Therapy	27,171		534,131	561,302		561,302		561,302			10a
11	Activities	83,628	6,508	831	90,967		90,967		90,967			11
12	Social Services	42,156		1,370	43,526		43,526		43,526			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Psychologist			6,917	6,917		6,917		6,917			15
16	**TOTAL Health Care and Programs**	2,340,662	387,156	1,023,091	3,750,909		3,750,909		3,750,909			16
	C. General Administration											
17	Administrative	69,348			69,348	188,578	257,926		257,926			17
18	Directors Fees											18
19	Professional Services			880,705	880,705	(424,733)	455,972	67,055	523,027			19
20	Dues, Fees, Subscriptions & Promotions			50,166	50,166	22,519	72,685	(27,461)	45,224			20
21	Clerical & General Office Expenses	151,786	45,882	61,077	258,745	68,935	327,680		327,680			21
22	Employee Benefits & Payroll Taxes			629,475	629,475	27,477	656,952		656,952			22
23	Inservice Training & Education			930	930	3,899	4,829		4,829			23
24	Travel and Seminar			25,583	25,583		25,583	(867)	24,716			24
25	Other Admin. Staff Transportation					8,856	8,856		8,856			25
26	Insurance-Prop.Liab.Malpractice			24,902	24,902	14,175	39,077	(2,720)	36,357			26
27	Other (specify):* Fund Raising					174	174	(174)				27
28	**TOTAL General Administration**	221,134	45,882	1,672,838	1,939,854	(90,120)	1,849,734	35,833	1,885,567			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,101,941	790,956	3,127,670	7,020,567	(80,729)	6,939,838	12,871	6,952,709			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number P A Peterson Home F/T Aged #0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			325,175	325,175	33,444	358,619	(1,129)	357,490			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			274,728	274,728	9,138	283,866	(3,027)	280,839			32
33	Real Estate Taxes			127,136	127,136		127,136	(1,401)	125,735			33
34	Rent-Facility & Grounds					32,369	32,369		32,369			34
35	Rent-Equipment & Vehicles			31,751	31,751	5,778	37,529	(1,519)	36,010			35
36	Other (specify):*											36
37	**TOTAL Ownership**			758,790	758,790	80,729	839,519	(7,076)	832,443			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation			419	419		419		419			38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			61,488	61,488		61,488		61,488			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			61,907	61,907		61,907		61,907			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,101,941	790,956	3,948,367	7,841,264		7,841,264	5,795	7,847,059			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(8,073)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,163)	5		5
6	Rented Facility Space	(1,711)	5		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(27,461)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	51,261			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 3,853		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(535)	35	34
35	Other- Attach Schedule	2,477		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,942		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,795		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

P A Peterson Home F/T Aged

ID# 0021238

Report Period Beginning: 7/01/99

Ending: 6/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non- LTC Space- Maintenance	$ (3,015)	6	1
2	Non- LTC Space- Insurance	(274)	26	2
3	Non- LTC Space- Depreciation	(3,583)	30	3
4	Non- LTC Space- R/E Taxes	(1,401)	33	4
5	Fund Raising	(174)	27	5
6	Allowable Mgmt & HR Allocation	70,518	19	6
7	Unallowed Service Net Allocation	(3,463)	19	7
8	Management Auto Depreciation	(1,007)	30	8
9	Insurance Premium Overpayment Refund	(2,446)	26	9
10	Non- LTC Space- Interest	(3,027)	32	10
11	Adjust in depr for IDPA Adjustments	2,477	30	11
12	Out of State Travel & Seminar	(867)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
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63				63
64				64
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66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	53,738		90

STATE OF ILLINOIS — Summary A

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(8,073)	0	0	0	0	0	0	0	0	0	0	(8,073)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(11,874)	0	0	0	0	0	0	0	0	0	0	(11,874)	5
6	Maintenance	(3,015)	0	0	0	0	0	0	0	0	0	0	(3,015)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(22,962)	0	0	0	0	0	0	0	0	0	0	(22,962)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	67,055	0	0	0	0	0	0	0	0	0	0	67,055	19
20	Fees, Subscriptions & Promotions	(27,461)	0	0	0	0	0	0	0	0	0	0	(27,461)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(867)	0	0	0	0	0	0	0	0	0	0	(867)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(2,720)	0	0	0	0	0	0	0	0	0	0	(2,720)	26
27	Other (specify):*	(174)	0	0	0	0	0	0	0	0	0	0	(174)	27
28	**TOTAL General Administration**	35,833	0	0	0	0	0	0	0	0	0	0	35,833	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	12,871	0	0	0	0	0	0	0	0	0	0	12,871	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(2,113)	984	0	0	0	0	0	0	0	0	0	(1,129)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(3,027)	0	0	0	0	0	0	0	0	0	0	(3,027)	32
33	Real Estate Taxes	(1,401)	0	0	0	0	0	0	0	0	0	0	(1,401)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	(535)	(1,519)	0	0	0	0	0	0	0	0	0	(2,054)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,076)	(535)	0	0	0	0	0	0	0	0	0	(7,611)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,795	(535)	0	0	0	0	0	0	0	0	0	5,260	45

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Vesper Mgmt.Corp.	Des Plaines, IL	Mgmt. Co.
				LSSI	Des Plaines, IL	Corp. Office
N/A		N/A	N/A			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		35	IS Equipment Rental	$ 1,519	Vesper Management Corp.	100.00%	$	$ (1,519)	1
2	V		30	Depreciation		Vesper Management Corp.	100.00%	984	984	2
3	V									3
4	V									4
5	V									5
6	V									6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 1,519			$ 984	$ * (535)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave., Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	28,067,775	270	$ 997,148	$ 997,148	2,761,510	$ 98,107	1
2	22	Empl Benefits & Taxes		28,067,775	270	162,007		2,761,510	15,939	2
3	19	Prof Fees & Contracts		28,067,775	270	3,858,301		2,761,510	379,607	3
4	21	Supplies, Telephone		28,067,775	270	602,840		2,761,510	59,312	4
5		Postage, Out Printing		28,067,775	270	0		2,761,510	0	5
6	34	Rental of Space		28,067,775	270	326,630		2,761,510	32,136	6
7	5	Utilities		28,067,775	270	32,855		2,761,510	3,233	7
8	6	Bldg Repairs & Maintenance		28,067,775	270	5,767		2,761,510	567	8
9	32	Interest		28,067,775	270	80,455		2,761,510	7,916	9
10	33	Real Estate Taxes		28,067,775	270	0		2,761,510	0	10
11	26	Insurance		28,067,775	270	143,300		2,761,510	14,099	11
12	27	Advertising & Promotions		28,067,775	270	1,767		2,761,510	174	12
13	25	Transportation		28,067,775	270	49,754		2,761,510	4,895	13
14	35	Car Rental		28,067,775	270	5,801		2,761,510	571	14
15	23	Conferences & Conventions		28,067,775	270	33,047		2,761,510	3,251	15
16	20	Subscriptions, Dues, Awards		28,067,775	270	18,746		2,761,510	1,844	16
17	21	Furniture & Fixtures		28,067,775	270	11,663		2,761,510	1,147	17
18	6	Machinery & Equipment		28,067,775	270	1,311		2,761,510	129	18
19	35	Equipment Rental		28,067,775	270	43,153		2,761,510	4,246	19
20	6	Equipment repair & Maint.		28,067,775	270	36,299		2,761,510	3,571	20
21	20	Employee Recruitment		28,067,775	270	50,702		2,761,510	4,988	21
22	7	Security & Waste Removal		28,067,775	270	17,105		2,761,510	1,683	22
23	21	All Other Miscellaneous		28,067,775	270	10,264		2,761,510	1,010	23
24	30	Depreciation		28,067,775	270	304,634		2,761,510	29,972	24
25	TOTALS					$ 6,793,549	$ 997,148		$ 668,397	25

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lutheran Social Services of Illinois
Street Address: 1001 E. Touhy Ave., Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Salaries & Benefits	47,987,195	270	$ 633,120	$ 633,120	3,731,415	$ 49,230	1
2	22	Empl Benefits & Taxes		47,987,195	270	90,256		3,731,415	7,018	2
3	19	Prof Fees & Contracts		47,987,195	270	142,094		3,731,415	11,049	3
4	21	Supplies, Telephone		47,987,195	270	58,353		3,731,415	4,537	4
5		Postage, Out Printing		47,987,195	270			3,731,415		5
6	34	Rental of Space		47,987,195	270	2,998		3,731,415	233	6
7	5	Utilities		47,987,195	270	138		3,731,415	11	7
8	6	Bldg Repairs & Maintenance		47,987,195	270	536		3,731,415	42	8
9	32	Interest		47,987,195	270	4,714		3,731,415	367	9
10	33	Real Estate Taxes		47,987,195	270			3,731,415		10
11	26	Insurance		47,987,195	270	688		3,731,415	53	11
12	27	Advertising & Promotions		47,987,195	270			3,731,415		12
13	25	Transportation		47,987,195	270	27,210		3,731,415	2,116	13
14	35	Car Rental		47,987,195	270	1,022		3,731,415	79	14
15	23	Conferences & Conventions		47,987,195	270	2,737		3,731,415	213	15
16	20	Subscriptions, Dues, Awards		47,987,195	270	164,037		3,731,415	12,755	16
17	21	Furniture & Fixtures		47,987,195	270			3,731,415		17
18	6	Machinery & Equipment		47,987,195	270			3,731,415		18
19	35	Equipment Rental		47,987,195	270	11,348		3,731,415	882	19
20	6	Equipment repair & Maint.		47,987,195	270	1,991		3,731,415	155	20
21	20	Employee Recruitment		47,987,195	270	31,485		3,731,415	2,448	21
22	7	Security & Waste Removal		47,987,195	270			3,731,415		22
23	21	All Other Miscellaneous		47,987,195	270	165		3,731,415	13	23
24	30	Depreciation		47,987,195	270	33,178		3,731,415	2,580	24
25	TOTALS					$ 1,206,070	$ 633,120		$ 93,781	25

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Luthran Social Services of Illinois
Street Address: 1001 E. Touhy Ave., Ste 50
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (847) 635-4600
Fax Number: (847) 635-6764

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries & Wages	Non-Capital Direct Costs	4,236,824	2	$ 63,273	$ 63,273	2,761,510	$ 41,241	1
2	22	Empl Benefits & Taxes		4,236,824	2	6,935		2,761,510	4,520	2
3	19	Prof Fees & Contracts		4,236,824	2	140		2,761,510	91	3
4	21	Supplies, Telephone		4,236,824	2	3,902		2,761,510	2,543	4
5		Postage, Out Printing		4,236,824	2			2,761,510		5
6	34	Rental of Space		4,236,824	2			2,761,510		6
7	5	Utilities		4,236,824	2			2,761,510		7
8	6	Bldg Repairs & Maintenance		4,236,824	2			2,761,510		8
9	32	Interest		4,236,824	2	1,312		2,761,510	855	9
10	33	Real Estate Taxes		4,236,824	2			2,761,510		10
11	26	Insurance		4,236,824	2	35		2,761,510	23	11
12	27	Advertising & Promotions		4,236,824	2			2,761,510		12
13	25	Transportation		4,236,824	2	2,830		2,761,510	1,845	13
14	35	Car Rental		4,236,824	2			2,761,510		14
15	23	Conferences & Conventions		4,236,824	2	667		2,761,510	435	15
16	20	Subscriptions, Dues, Awards		4,236,824	2	732		2,761,510	477	16
17	21	Furniture & Fixtures		4,236,824	2			2,761,510		17
18	6	Machinery & Equipment		4,236,824	2			2,761,510		18
19	35	Equipment Rental		4,236,824	2			2,761,510		19
20	6	Equipment repair & Maint.		4,236,824	2			2,761,510		20
21	20	Employee Recruitment		4,236,824	2	10		2,761,510	7	21
22	7	Security & Waste Removal		4,236,824	2			2,761,510		22
23	21	All Other Miscellaneous		4,236,824	2	573		2,761,510	373	23
24	30	Depreciation		4,236,824	2	1,368		2,761,510	892	24
25	TOTALS					$ 81,777	$ 63,273		$ 53,302	25

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1993 Bond Refinancing		X	Refinance Mortgage	N/A	9/23/93	$ 1,991,385	$ 3,595,130	8/15/01	7.3800	$ 273,853	1
2	1995 Capital Lease		X	Phone System	$1,119.00	11/15/95	56,283	2,219	8/16/00	7.1900	870	2
3	1996 Capital lease		X	Paging System	$275.00	8/14/96	7,828		7/14/99	15.9100	5	3
4												4
5												5
	Working Capital											
6	Mgmt Allocation (per schVIII)	X		Management Allocation	N/A	N/A	N/A	N/A	N/A	N/A	9,138	6
7												7
8												8
9	TOTAL Facility Related				$1,394.00		$ 2,055,496	$ 3,597,349			$ 283,866	9
	B. Non-Facility Related*											
10	Non-LTC use of Facility Space			Offset Against Interest Expens	N/A	N/A	N/A	N/A	N/A	N/A	(3,027)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (3,027)	14
15	TOTALS (line 9+line14)						$ 2,055,496	$ 3,597,349			$ 280,839	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	135,100	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	128,173	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,927)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	134,063	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	127,136	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	161,592	8
	1996	100,347	9
	1997	127,393	10
	1998	128,667	11
	1999	127,680	12

Line 2: Payment of $128,173 represents $ 64,333 for 1998 and $63,840 for 1999

Line 4: Accrual of $ 134,063 is based on second half of 1999 of $63,840 and estimates first half of 2000 of $70,223

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 110,000 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 3

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	192,020	1985	$ 8,455	1
2					2
3	TOTALS	192,020		$ 8,455	3

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	168		1942	1942	$ 95,858	$	50	$	$	$ 95,858	4
5			1979	1979	5,596,922	140,306	40	140,306		2,938,768	5
6											6
7											7
8											8
	Improvement Type**										
9	1944 Addition			1944	50		50			50	9
10	1948 Addition			1948	157		50			157	10
11	New roof			1969	2,119		25			2,119	11
12	Boiler			1969	5,300		20			5,300	12
13	Ground Improvements			1971	2,400		15			2,400	13
14	New doors			1973	4,326	155	28	155		4,174	14
15	Electric Alarm System			1974	2,056		15			2,056	15
16	1975 Addition			1975	9,226		20			9,226	16
17	Remodeling			1977	10,074		16			10,074	17
18	Addition to Bldg			1980	2,874	74	39	74		1,475	18
19	Grab Bars			1982	6,151		10			6,151	19
20	Automatic Door Controls			1983	10,386		10			10,386	20
21	Remodel Suites to singles			1983	20,550		10			20,550	21
22	Screen patio Cover			1984	1,205		10			1,205	22
23	32 Storm Windows			1984	2,080		10			2,080	23
24	Convert Suites to Rooms			1984	11,900		10			11,900	24
25	Remodel Suites to singles			1986	15,800		10			15,800	25
26	New Drop Ceiling			1991	750	75	10	75		713	26
27	Repair Damaged Roof			1993	4,296	431	10	431		2,794	27
28	Second Floor Redecoration			1994	89,701	8,995	10	8,995		58,171	28
29	Adjustment per IDPA 2nd Flr Decorating			1994	(2,730)		10	(273)	(273)	(1,775)	29
30	Floor Cleaning Equipment			1979	1,360		10			1,360	30
31	Electrical Work			1980	726		10			726	31
32	Painting			1980	3,253		10			3,253	32
33	Carpenting			1980	5,076		10			5,076	33
34	Landscaping			1980	69,073		10			69,073	34
35	Landscaping - Final 1980			1981	7,309		10			7,309	35
36	TOTAL (lines 4 thru 35)				$ 5,978,248	$ 150,036		$ 149,763	$ (273)	$ 3,286,429	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Nurse call system- Basement			1983	1,700		10			1,700	9
10	Carpeting			1984	1,503		10			1,503	10
11	Nurse Call Control Board			1984	2,900		10			2,900	11
12	Sprinkler System			1984	3,654		10			3,654	12
13	Paving			1985	4,850		10			4,850	13
14	Electrical Wall Fixtures			1985	6,605		10			6,605	14
15	Deluxe Tub with Lift			1986	5,840		10			5,840	15
16	Electrical Wall Fixtures			1986	6,575		10			6,575	16
17	2nd Floor Shower Room			1988	13,898		10			13,898	17
18	Improvements			1988	4,414		10			4,414	18
19	Improvements			1989	15,688		10			15,688	19
20	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS			1989	20,266		10			20,266	20
21	ADJUSTMENT PER IDPA- 1989 IMPROVEMENTS			1989	35,052		10			35,052	21
22	New Compressor			1989	1,272		7			1,272	22
23	Call Devices			1990	1,400	70	10	70		1,400	23
24	New Roff			1990	41,995	1,684	25	1,684		17,640	24
25	Public Address System			1990	4,200		5			4,200	25
26	First Floor Remodeling			1990	62,210	2,495	25	2,495		23,650	26
27	ADJUSTMENT PER IDPA- 1990 1rst Flr Remodeling			1990	(3,590)		25	(144)	(144)	(1,508)	27
28	Parker Bath Tub			1991	9,390		7			9,390	28
29	Cubical Curtains			1991	1,075		7			1,075	29
30	Laundry Room Remodeling			1991	2,082	209	10	209		1,858	30
31	Third Floor Remodeling			1992	99,312	9,958	10	9,958		84,429	31
32	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling			1992	(78,784)		10	(7,878)	(7,878)	(66,966)	32
33	ADJUSTMENT PER IDPA 1992 3rd Flr Remodeling			1991	54,938		10	5,494	5,494	52,191	33
34	Underground Fual Tank			1993	10,523		5			10,523	34
35	Security Cameras			1993	3,496		5			3,496	35
36	TOTAL (lines 4 thru 35)				$ 332,464	$ 14,416		$ 11,888	$ (2,528)	$ 265,595	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bath Tub			1995	3,766	378	10	378		1,748	9
10	Parking lot			1995	16,425	659	25	659		2,959	10
11	IDPH Remodeling			1995	162,992	16,344	10	16,344		73,413	11
12	New Subacute Unit			1995	677,548	27,176	25	27,176		122,070	12
13	Adjustment per IDPA - 1995 Improv to equip			1995	(63,067)		25	(2,523)	(2,523)	(13,876)	13
14	Adjustment per IDPA - 1995 Improv to CORF			1995	(30,219)		25	(1,209)	(1,209)	(6,647)	14
15	Parking Lot # 94-502			1995	416	42	10	42		187	15
16	Carpet/Vinyl Dining Room			1995	12,220	1,225	10	1,225		5,501	16
17	Glass & Glazing for Door			1997	775	78	10	78		248	17
18	New Doors & Smoke Closer			1997	1,910	192	10	192		573	18
19	Floor Covering in Kitchen			1998	2,047	205	10	205		478	19
20	Repair Roof-P.A.P.			1998	53,433	2,143	25	2,143		4,275	20
21	Zoning Permit Parking Lot			1998	898	90	10	90		172	21
22	Planting & Mulch for P.A.			1998	7,186	721	10	721		1,376	22
23	Parking Lot Expansion			1998	778	78	10	78		149	23
24	North Parking Lot Remodeling			1998	80,391	8,063	10	8,063		15,395	24
25	Consulting N. Parking Lot			1998	806	81	10	81		147	25
26	Repair Conduit Damage			1998	3,982	399	10	399		630	26
27	Carpeting for Apartment C			1999	17,200	3,440	5	3,440		3,440	27
28	Corridor Ventilation Upgr			2000	63,500	202	25	202		202	28
29											29
30											30
31											31
32	Management Assets- Security System			1999	7,906		10	85	85	N/A	32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,020,893	$ 61,516		$ 57,869	$ (3,647)	$ 212,440	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 632,501	$ 74,564	$ 93,796	$ 19,232	Various	$ 223,942	37
38	Current Year Purchases	448,404	22,645	35,764	13,119	Various	24,409	38
39	Fully Depreciated Assets	459,224	11,009	11,009		Various	459,224	39
40								40
41	TOTALS	$ 1,540,129	$ 108,218	$ 140,569	$ 32,351		$ 707,575	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Trans.	Handicapped Bus	1991	$ 38,800	$	$	$	7	$ 38,800	42
43										43
44										44
45										45
46	TOTALS			$ 38,800	$	$	$		$ 38,800	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 8,918,989	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 334,186	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 360,089	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 25,903	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 4,510,839	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	92 Chevy Corsica 1992	$ 11,219	$	$ 11,219	52
53	Management Autos	7,026		N/A	53
54	95 Improvement- CORF 1995	30,219	1,209	6,647	54
55					55
56					56
57	TOTALS	$ 48,464	$ 1,209	$ 17,866	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 30,232 Description: See Attached Schedule
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1	2	3	4
			Facility			
			Drop-outs	Completed	Contract	Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies					
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)	N/A			
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS		$	$	$	$
10	SUM OF line 9, col. 1 and 2	(e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 0

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts		N/A			#VALUE!		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$	#VALUE!	$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number P A Peterson Home F/T Aged **#** 0021238 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 6/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	N/A		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$	48

***(See instructions.)**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ N/A	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)		7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$	24 *

Note: Lutheran Social Services of Illinois is unable to provide meaninful comparative balance sheets or statements of changes in equity for individual programs due to the commingling of cash, other assets, and most liabilities in a complex, multi-functional service agency.

Any Balance Sheet prepared with only those Assets with specific programs would not balance or present a meaningful picture of that program's Financial Status.

*** This must agree with page 17, line 47.**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,206,056	1
2	Discounts and Allowances for all Levels	(782,599)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,423,457	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	2,986	13
14	Non-Patient Meals	8,073	14
15	Telephone, Television and Radio	22,256	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	3,916	20
21	Other Medical Services		21
22	Laundry	16,594	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 53,825	23
	D. Non-Operating Revenue		
24	Contributions	206,489	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 206,489	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)	2,446	27
28	Vending Machine Income	2,042	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,488	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,688,259	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,329,804	31
32	Health Care	3,750,909	32
33	General Administration	1,939,854	33
	B. Capital Expense		
34	Ownership	758,790	34
	C. Ancillary Expense		
35	Special Cost Centers	419	35
36	Provider Participation Fee	61,488	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,841,264	40
41	**Income before Income Taxes (line 30 minus line 40)****	(153,005)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (153,005)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,799	1,917	$ 51,117	$ 26.67	1
2	Assistant Director of Nursing	3,416	3,917	84,199	21.50	2
3	Registered Nurses	33,318	37,739	626,603	16.60	3
4	Licensed Practical Nurses	41,252	46,104	651,241	14.13	4
5	Nurse Aides & Orderlies	62,814	68,310	688,386	10.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,475	2,897	27,171	9.38	8
9	Activity Director	3,784	4,465	81,977	18.36	9
10	Activity Assistants					10
11	Social Service Workers	1,954	2,213	27,285	12.33	11
12	Dietician	1,039	1,278	16,827	13.17	12
13	Food Service Supervisor	3,912	4,377	56,077	12.81	13
14	Head Cook	5,965	6,529	56,550	8.66	14
15	Cook Helpers/Assistants	21,628	23,548	161,173	6.84	15
16	Dishwashers					16
17	Maintenance Workers	7,037	8,225	115,318	14.02	17
18	Housekeepers	15,028	16,771	119,879	7.15	18
19	Laundry	1,305	1,479	14,321	9.68	19
20	Administrator	1,878	2,068	69,347	33.53	20
21	Assistant Administrator					21
22	Other Administrative	3,660	4,174	69,351	16.61	22
23	Office Manager					23
24	Clerical	8,948	9,748	82,435	8.46	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,836	8,961	86,161	9.62	31
32	Other Health Care(specify)					32
33	Other(specify)	807	902	16,523	18.32	33
34	TOTAL (lines 1 - 33)	229,855	255,622	$ 3,101,941 *	$ 12.13	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	As Needed	$ 20,641	1/3	35
36	Medical Director	As Needed	34,071	9/3	36
37	Medical Records Consultant	As Needed	14,000	19,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	As Needed	1,729	10/3	39
40	Physical Therapy Consultant	As Needed	406,226	10a/3	40
41	Occupational Therapy Consultant	As Needed	92,968	10a/3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	As Needed	34,937	10a3	43
44	Activity Consultant				44
45	Social Service Consultant	As Needed	1,370	12/3	45
46	Other(specify) (see attached)	As Needed	136,450	Various	46
47	Legal & Audit/Accounting	As Needed	132,279	19/3	47
48					48
49	TOTAL (lines 35 - 48)		$ 874,671		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	As Needed	$ 13,035	10/3	50
51	Licensed Practical Nurses	As Needed	51,722	10/3	51
52	Nurse Aides	As Needed	358,883	10/3	52
53	TOTAL (lines 50 - 52)		$ 423,640		53

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Peggy J. Holt	Administrator	0.0%	$ 69,348
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 69,348

B. Administrative - Other

Description	Amount
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Architect	Gary Anderson & Assoc.	$ 458
RSM McGladrey Inc	Medicare Cost report Prep	3,132
Polaris Group	Medicare Consultation	89,862
Frost Ruttenberg	Medicare Consultant	19,493
Duane, Morris & Heckscher	Legal Fees	19,337
LSSI	Managament Services	748,423
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 880,705

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 78,600
Unemployment Compensation Insurance	29,442
FICA Taxes	229,025
Employee Health Insurance	274,777
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension	17,631
Management Allocation	27,477
TOTAL (agree to Schedule V, line 22, col.8)	$ 656,952

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	13,933
Health Care Worker Background Check (Indicate # of checks performed)	
Licenses & Fees	
Advertising & Promation, Awards, Grants	27,460
Subscriptions & Books	3,418
Membership Dues	5,355
Management Allocation	22,519
Less: Public Relations Expense	( )
Non-allowable advertising	(27,461)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 45,224

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Employee Mileage, Meals, Lodging	787
Conference & Convention	80
In-State Travel	
Vehicle Operating Cost	4,935
Employee Mileage Payments	5,256
Meals, Lodging	1,197
Seminar Expense	10,076
Conference & Convention	3,252
Less Out of State Travel & Seminar	(867)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,716

**See instructions.

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 Report Period Beginning: 7/01/99 Ending: 6/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6	N/A												
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number P A Peterson Home F/T Aged # 0021238 **Report Period Beginning:** 7/01/99 **Ending:** 6/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network $ 5,031**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,768** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. **No**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **61,488**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **8,073**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Clifton Gunderson** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **In Progress, will send as soon as avail**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.